MARCH 1956

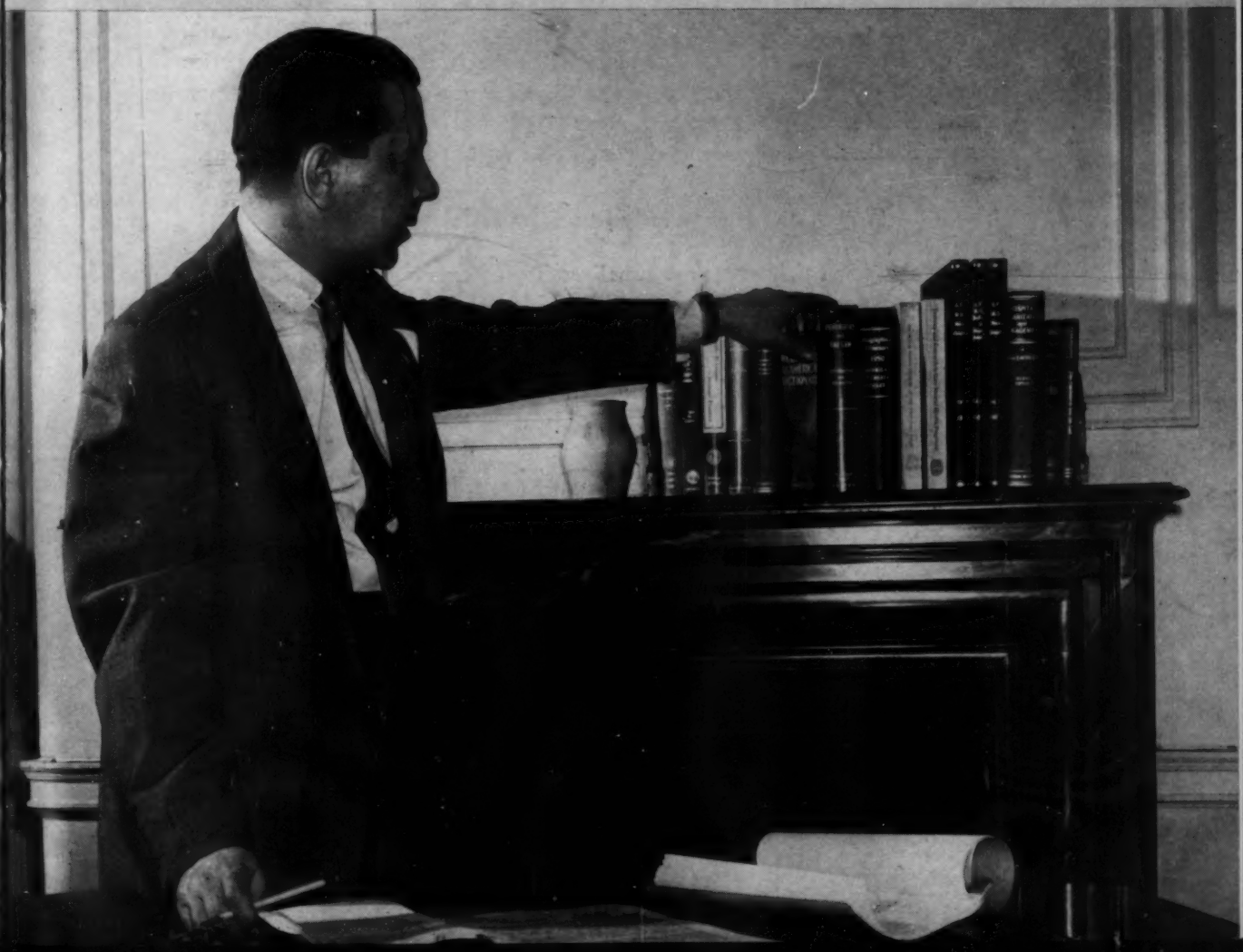
# Mental Hospitals

DEVELOPING
GOOD PUBLIC RELATIONS

REHABILITATION OF
THE MENTALLY ILL

THE INSTITUTE FOR
PSYCHOSOMATIC & PSYCHIATRIC
RESEARCH AND TRAINING

American Psychiatric Association



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Mental Hospitals

Volume 7
Number 3



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(Cover design by Henry D. Chaplin)

## THIS MONTH'S COVER

From the very inception of the American Psychiatric Association, one of its cardinal tenets has been that the superintendent of a mental hospital should be a physician experienced in the care and treatment of the mentally ill—or, as we should say today, a trained psychiatrist. So intimately concerned is every aspect of the operation of the hospital with the welfare and treatment of the patient that medical judgment is involved in every decision which is made by the superintendent. The situation in the compact social community which is the mental hospital is not at all similar to that of the general hospital, and any comparison of the two is basically specious.

It is not enough, of course, that the administrator of the mental hospital be a psychiatrist. He must have executive and business ability and training and be able to select competent lieutenants in the several fields of activity involved in the operation of the institution. He need not attempt to be an engineer, a financier, or a personnel expert, but he must be in a position by training and temperament to evaluate the manner in which activities in these and the other fields will react upon the welfare of the patients.

With the development of training courses and certifying bodies for lay (general) hospital administrators it became clear that the A.P.A. should take steps to set up standards for mental hospital administrators. This need was seen with special clarity by the late Dr. Crawford N. Baganz; it is due to his vision and energy that the Association in 1953 authorized the establishment of a permanent Committee on the Certification of Mental Hospital Administrators. Doctor Baganz served most efficiently as Secretary of the Committee until his untimely death in December 1955.

Space does not permit a recital of the details of the requirements for certification, nor the steps which are being taken to organize courses of training for presently prospective mental hospital administrators. Such courses are in the process of organization at several recognized universities.

MENTAL HOSPITALS commences in this issue a series of articles on the various phases of hospital administration, such as professional staffing, legal aspects, budget preparation and control, procurement, organization, food service, and so on. These articles have been prepared by authorities in their fields. Their subject matter will follow the division listed in the Rules and Regulations of the Committee, in which candidates will be examined for Certification as Mental Hospital Administrators. While these articles cannot completely cover the field, an attempt has been made to cover all essential points in each category. It is hoped to collect them together and make them available in the form of a reprint when the series is completed.

These articles are presented here in the hope that they may not only prove instructive, but that they may illustrate the varied aspects of mental hospital administration as a field which offers many satisfactions.

WINFRED OVERHOLSER, M. D.,
Chairman,
Committee on Certification of
Mental Hospital Administrators

Comment on the use of 'Thorazine' in a mental hospital:

*"we have ceased to regard any of our patients as 'incurable'"*

"Admittedly our recovery rates have tended to decrease progressively as chronicity increases. However, we have encountered several seemingly 'miraculous' responses in patients hospitalized ten years or more and previously regarded as just about hopeless."[1]

THORAZINE* is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

For information write: *Smith, Kline & French Laboratories, Philadelphia 1*

1. Yohe, C.D.: in Chlorpromazine and Mental Health, Philadelphia, Lea & Febiger, 1955.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

*No. 1 in a Series on Mental Hospital Administration*

# DEVELOPING GOOD PUBLIC RELATIONS

## The techniques and application of community relations including methods and media

By J. O. CROMWELL, M. D.

Superintendent, State Hospital South, Blackfoot, Idaho

ONE OF the primary responsibilities of the administrator of a public mental hospital is to develop good community relations. He accomplishes this through his application of certain principles to the operation of the hospital. Let us consider some of these:

***Take cognizance of the situation:***

Many patients in our mental hospitals are locked up. To them and their friends it appears that their personal rights and privileges are being ignored and denied. The buildings are generally over-crowded, many of poor construction and poorly planned for their present use; some are over-aged, crumbling, vermin-infested, unsanitary and constitute a real menace as fire and earthquake traps. The diet may be inadequate from the standpoint of quantity, quality, or preparation and serving—or in all four aspects. More often than not the professional staff will be too few in number, often unsuited for their work by temperament, general health, training, or all three. The equipment for dormitory, dayroom, or professional use is generally inadequate. While some parts of the hospital may have beautiful new items, others are of such archaic vintage as to be hazardous.

The general public is uninformed about and afraid of mental illness. Tax burdens are truly heavy—yet progress and improvements in the situation depend upon increased financial resources. Many other State functions must compete for the tax dollar. Methods of increasing per capita resources must claim our attention. Existing fiscal and personnel policies, sometimes determined by political expediency, are unrealistic—yet receive considerable support from present public opinion. Much prejudice, superstition and misinformation exist concerning mental illness, the hospitals and clinics which deal with it, and the duties, practices and intentions of the officials, staff, and personnel of these institutions. This is the situation that confronts us.

***Define an acceptable situation and establish a long-term objective:***

Our mental hospitals should operate as nearly as possible like good community general hospitals, which are held in high regard. We should be guided by a comparable philosophy of admission, professional responsibility, fiscal dealing, outpatient treatment and follow-up, equipment and structural standards, and visiting policies.

This means patients should enter and leave voluntarily. They should choose their doctor, and have some freedom to choose another if dissatisfied. Consultations should be called in making difficult or controversial medical decisions. Wards should be small and never overcrowded. Only modern fire-resistant construction should be used in new construction. Locked wards should be few in number and individuals placed in them only when such measures are clearly for the patient's or the public's welfare—and then for the minimal practicable time.

Patients should be held responsible for their own fiscal accounts when financially able to do so; seldom will this be detrimental to their mental welfare. The administrator of the hospital should be held responsible for collections. Funds collected should go to the hospital. Professional services as well as general hospital care should be charged for and all business transactions should be *realistic*—clearly understood and honestly presented—yet no one must be denied admission because of inability to pay.

Visitors should be welcome at all times. Only the exceptional, acutely ill patient should be considered too ill to have visitors. Nothing about the hospital, except confidential medical information directly bearing on patients, should be withheld from the public. Secrecy perpetuates suspicion. Visitors should be welcome on all wards and should do at least part of their visiting on the ward dayrooms so that they get to know and feel the "atmosphere" of the hospital.

The sexes should be separated only when this is clearly necessary. Social intercourse should be encouraged and accepted as desirable and natural, as it is on the "chronic" wing of a general hospital.

An informed public, alert to social reality, would view mental illness as it does measles. Good family care would be the "first line of defense." The family doctor, oriented toward psychiatric treatment, would be the foundation upon which good professional care and advice is based. A "specialist" in mental disease should be available in every community, and each large community should have a clinic, headed by a psychiatrist backed up by all the

special talent needed to make it an all-purpose, balanced organization. The general hospital should have a psychiatric ward, and might be the physical home of the clinic. Only the long-term or difficult case would be referred eventually to a state-operated mental hospital; and this state hospital should be operated at such standards that the very best methods known to science can be utilized and applied in the treatment of patients.

In some such terms will the acceptable situation and long term objective be defined. Each point in this "acceptable situation"—as it applies to the hospital, and as it applies to Mr. John Public—needs to be honestly faced by administrators, and thoroughly discussed with staff and advisors until those responsible for public relations know exactly toward what goals they are working. Nothing so motivates an individual or a group as a worthwhile cause. It focuses thoughts and actions and leads to constructive change. Without a cause people work at cross-purposes and accomplish nothing. In establishing good public relations we hospital administrators must know our goals if we hope to change our hospitals, change public opinion and mobilize public support.

***Plan continuously:***

It is the continuous function of the public relations officer* to formulate and present to the chief administrator, for his approval, a good public relations plan. Steps to follow in such planning are:

Consider methods available which would help "transmute the prevailing forces" from what they are to what we consider more acceptable. A suggested list might include:

*Methods which primarily involve the hospital:*

Open-door policy for visitors.

Increase number of "full privilege" open ward patients to maximum and reduce locked wards, seclusion, and restraint to minimum.

Promote normal social interaction on all wards and on the campus.

Develop a Volunteer Service program.

Develop an educational program which *continuously* reaches all personnel.

Strive for the American Psychiatric Association Standards of operation; educate all employees to know what this means.

Establish a good personnel policy.

Operate food service department at high standard.

Advocate and instigate modern admission procedures as outlined in the Draft Act Governing Hospitalization of the Mentally Ill.

*Methods which primarily aim at changing public opinion:*

Promote good press relations

Provide public speakers.

Become "extension course" teachers for neighboring colleges for courses in mental health.

Exploit "Hospital Day," and Mental Health Week by inviting the public to visit the hospital.

Welcome visiting classes from high schools.

Have employees live in town.

Encourage and aid employees to participate in community activities, civic organizations, and church groups.

Sponsor conferences, panel discussions and work shops for special lay groups at the hospital and with hospital personnel participating.

Analyze the existing situation to determine which of the above need doing most urgently, and which offer the greatest prospects for success.

Decide what to undertake first. Perhaps your first actions will involve only the major administrative personnel—but before a final decision is made the entire professional staff should be alerted and their ideas solicited. In the light of their suggestions a final decision should be made on what projects to undertake.

Having established a plan and outlined a project, details must be worked out. Suppose that yours is a hospital with 95 percent of the patients locked securely behind iron doors—and you have decided, and your staff agrees, that unlocking as many patients as possible would build better public relations. A period of weighing the pros and cons by the professional staff should follow. Be sure the staff feels the decision is medically sound and that they will support it 100 percent.

Before the project is actually started, all the graduate nurses should be informed, the objectives explained, and their support and suggestions solicited. The attendants should likewise be approached, and so should the maintenance personnel. When everybody knows about it—and when you are sure certain key members of each group will give the plan their full support—then it is time to implement the project. This is best done by placing a few more patients on the "full privilege" ward each week, or by increasing the number of full privilege campus pass cards to patients on locked wards. Do it slowly, but deliberately, until you finally establish the optimal number of patients to place on full privilege status. Thus, the details are worked out day by day as problems arise.

***Make the most of a lucky break:***

The best of plans cannot foresee all the opportunities the future will present. One thing often leads to a chance to take an unplanned step. When the author was desperately trying to fill a medical vacancy, an unforeseen opportunity to add an extraordinarily competent music therapist turned up. Exploiting this opportunity has not only paid tremendous dividends in patient care, but also in public relations, for our music therapist is one of the best "public relations experts" the hospital has ever had.

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* **Ed. Note:** *Despite budgetary limitations, most hospitals would do well to consider the establishment of a Public Information Officer on a full or part-time basis, to relieve the superintendent of the many duties involved in working with various media. While this individual will be properly trained to carry out such duties, the full responsibility for the program cannot be delegated to him. The psychological leadership remains vested in the superintendent, because of his professional knowledge of the needs of the patients and the attitudes of of the public towards the hospital and towards mental illness.*

# "CLEAN, COOPERATIVE, AND COMMUNICATIVE"

Under the influence of Serpasil, patients who had been destructive, resistant, hostile, withdrawn, untidy, or troubled with hallucinations became, in a short period of time, "clean, cooperative, and communicative persons."[1]

Serpasil has been shown to be effective even in violently disturbed psychotics *if sufficiently high dosage is used.* After 6 to 8 weeks of Serpasil therapy in 127 chronic schizophrenics "the result was frequently astounding, even to psychiatrists of long clinical experience."[1]

In similar studies, the worst behavior problems in the hospital showed improvement, chiefly ". . . a reduction of motor activity, of tension, of hostility, and aggressiveness."[2] Many reports have indicated that Serpasil may be substituted for electro- or insulin shock and that it sharply reduces destruction and assaults in the violent back wards.

*Adequate trial is essential*—a minimum of 3 months, beginning with "parenteral doses of at least 5 mg. of reserpine and continued daily doses of 2 to 8 mg. orally."[1] "The occurrence of the turbulent phase (with exaggeration of symptoms) is *not* an indication for discontinuing treatment."[3]

1. Hollister, L. E., Krieger, G. E., Kringel, A., and Roberts, R. H.: Ann. New York Acad. Sc. *61*:92 (April 15) 1955. 2. Hoffman, J. L., and Konchegul, L.: Ann. New York Acad. Sc. *61*:144 (April 15) 1955. 3. Kline, N. S., and Stanley, A. M.: Ann. New York Acad. Sc. *61*:85 (April 15) 1955.

*Parenteral Solution*, 2-ml. ampuls, 2.5 mg. Serpasil per ml. *Tablets*, 4.0 mg. (scored), 2.0 mg. (scored), 1.0 mg. (scored), 0.25 mg. (scored) and 0.1 mg. *Elixir*, 1.0 mg. and 0.2 mg. Serpasil per 4-ml. teaspoon.

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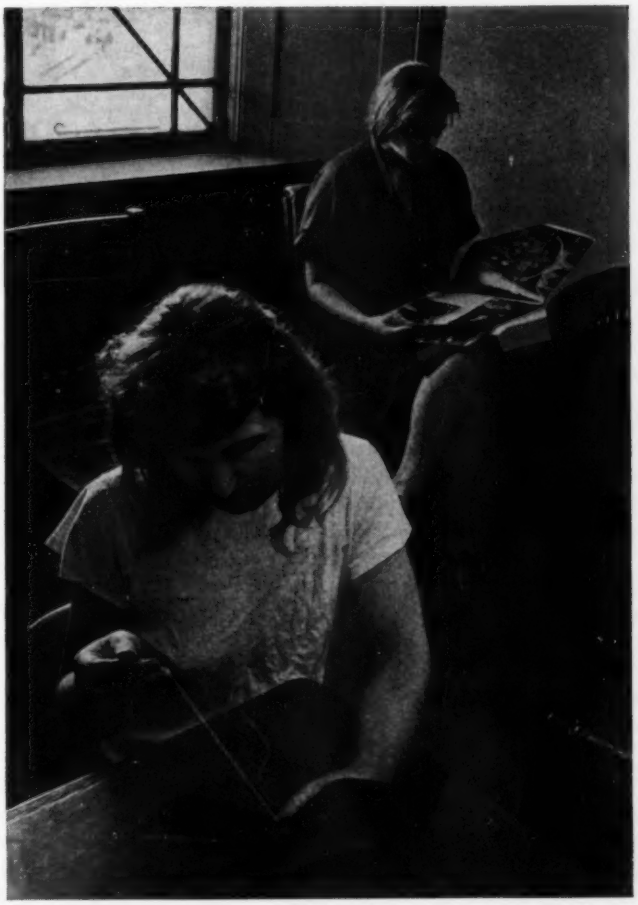

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***Encourage people to do things for the hospital—facilitate, recognize, and appreciate their efforts:***

People become identified with a cause when they sacrifice a bit for it. The volunteer who contributes one hour a week working in a hospital ward is a far more enthusiastic hospital supporter than someone who puts forth no effort to make it a good hospital. The women's club that sponsors a project of raising funds, collecting clothing, or wrapping Christmas gifts for the patients in the hospital, supports and becomes interested in the hospital far more than the club that just has an occasional program on the problems of the hospital but exerts no other effort in its behalf. Every time a club or a person calls the author and offers a service or a gift to his hospital, he accepts it—even though the effort hospital personnel may have to expend in "gleaning the chaff from the wheat" exceeds the value of the gift. Get a person to give you old rags and he will soon be giving you his interest, good will and support, and these are the essence of "good public relations." Then don't forget! Occasionally let him know how valuable his contribution is, and how greatly you appreciate it.

***Accept mild disadvantages in order to reap long-term advantages:***

A consideration of the open house visiting policy illustrates this principle. Too arbitrarily and too consistently holding to some established and quite good practices will never lead to public understanding of our problems. Our patients are sick. Some of them do need peace and quiet, and are surely upset by too many visitors. The policy many hospitals follow of short visiting hours, visiting only by next of kin, visiting only in visiting rooms, keeping the public off most wards, and the wards as quiet as possible has certain advantages for *some* patients. It may also be argued that some patients immediately benefit from visitors. But both these arguments miss the real point of freely welcoming any and all visitors at all times. The public believes that many weird things occur on "closed wards." They imagine all sorts of ridiculous things take place. This can only be offset by the experience of *visiting all the wards.* The public reads in the press that hospitals need more tax money, that conditions of indescribable poverty and overcrowding exist in mental hospital wards. But reading a thousand news reports lacks the conviction of just one visit through such wards. Whenever groups visit, a short explanatory talk by a staff member is a wise investment of time.

It is true we should not, and will not, intentionally put our patients "on display". We do not want mere curiosity-seekers to flock to our hospitals, stare at our patients and consider the tragedy they behold as a joke. But we can say from experience that such things rarely occur. In some 15 years of following an "open door" policy, open to all comers—relatives, friends, or strangers—we have not once seen nor had reported to us any untoward incident of this nature. Yet each year thousands of visitors have poured through the hospital. Rather, can we attest that this open door policy has done more to dispel false beliefs and to impart knowledge of the true situation than any other thing that has guided us in promoting "good public relations."

It is true that a few patients have become genuinely upset by visitors. Possibly a very few have actually been given a set-back or made worse. But in terms of ultimate gain, through the enlightenment of visitors, this hospital has recruited the services of many volunteer workers, has received many valuable gifts, and has been able to effect many placements and discharges. Certainly we owe, in part, our increased resources and increased standard of care attained over the past few years to this policy.

***Establish realistic fiscal policies:***

Nothing is so unrealistic as attempting to treat a wealthy person in a state hospital—then collecting $20.00 a month for your services. The administration should have some clear-cut views on what is "good financial policy", and make every effort to establish it. To do so sounds like good sense to most people, including tax payers and legislators. We believe that the more a state hospital does for itself, the more tax support it will receive, and we have proved it over the past 18 years.

The usual situation is that only a token payment is asked of those "able to pay", the money collected goes to the State's "General Fund", and the responsibility for setting the stipend and collecting it is vested in the "central authority." This is nonsense—but the rationalizations one hears for it are, "It is good politics"; "Patients can't pay anyway"; "It makes great hardships on the patient and his family to ask that anyone pay the cost of his care." In no other business (and state hospitals are real, big business) would such maudlin sentimentality be tolerated. Certainly no other type of hospital expects those who are able to pay to make only token payments for the services they receive.

The author believes that *the charge made against all patients should be the actual cost of their care and treatment.* In this hospital this is $120.00 a month for routine hospital care, plus the actual cost of treatment. In general, "treatment" is charged for at the rate of $10.00 for every hour a doctor spends with a patient. *This is actual cost.* All patients are told of these charges and asked to agree to make whatever monthly payments they can. If a patient is too ill, then his next of kin is asked to make the agreement. If unable to pay, then public assistance investigates and we enter in the record "to be paid by tax funds." Of course most patients are actually supported, at least partially by tax funds. We collect only what we can without undue hardship to the patient or his family.

This policy has produced *increasing* amounts of "local income" and as a consequence the legislature has also increased the tax support in each of the past seven sessions. We get no more, in fact not as many complaints about the charges as we got when we charged only $20.00 a month. The public feels better about the whole matter. The chances are that the "local income" will continue to rise as more and more money is entered as charges and eventually settled by estates, and inheritances, as well as by current payments.

***Identify with the local community:***

All too often the community tends to ostracize the state hospital personnel; the personnel seek refuge by defensively avoiding the community. Such action is unproductive of good relations.

The neighboring communities are all-important to the hospital. It they accept the employees of the hospital they will come to accept the hospital. If the "home town" comes to take pride in the hospital it will have profound influence on all other communities. Woo the good-will of the home folk.

To do this the administrator must set the pace. He should join local organizations, socialize in town, participate in local welfare activities, contribute his talents as a speaker whenever the opportunity presents itself, and encourage his staff to do so. If it is practical and possible, he should work toward having employees live in town, and live there himself.

Keep the local Chamber of Commerce aware of the size of your payroll. Its members know the good this brings to the town. Welcome civic activities at the hospital; allow the use of the recreation hall for an evening; lend your projection equipment; occasionally stage a dinner for some club. Public relations is a two-way proposition, but you get tremendous returns so even your generosity can be called selfish! By accepting the community, identifying with it, becoming actively involved in its problems, the pay-off is that the community accepts the hospital. You can't lose!

***Hold the Legislator in high regard:***

Too often, in talking with administrators, we hear aspersions cast on legislators. This is bad manners and bad public relations. The legislator is human. He represents his constituents as honestly as he knows how. Like you, he resents attack, and welcomes respect—and believe me, he deserves it. Theoretically he can support the hospital appropriation only as much as the public does. But throughout America the legislators are at least up with the public. In many places it is the legislator who is the leader in the mental health movement. Let him know your problems, and especially let his wife know. Then trust to his judgment and sense of integrity to do what is best for your hospital and the State as a whole. By and large, that is exactly what he will do.

***Hail the Employee—Mr. Ambassador:***

The most active ambassadors of any hospital are its employees. They have tremendous influence in shaping its public relations. Like the rest of humanity, they radiate the emotions which are aroused by their working conditions. To insure that the "emotional emanations" of the employees are predominantly of a positive character the administrator must take their problems to heart. Improve their working conditions, provide for safety, provide for first aid, gratify their ego needs by recognition, increased responsibility awards, and encouragement for a job well done. Work toward having them live in the community. Life on the campus is not a good life. It's no substitute for wholesome community life. One needs to be com-

pletely away from one's work a part of the day. The administrator of a hospital should, of course, try to keep the salary scale commensurate with the best the community has to offer. A happy, well-paid employee is the best public relations asset!

***Be available:***

Too many administrators live in an ivory tower. They are "too busy" to meet the many people who knock at their door—salesmen, employees, patients, families, friends, students. If you're hard to see, you're undermining your public relations. Certainly you cannot spend time enough to fully satisfy the many people who make demands on you. But you can give them a word—refer them to someone who can spend the time needed. To be sure, your secretary can see if it's just as satisfactory to talk to someone else, your receptionist can make the same inquiry—but see those who clearly want to see *you*, even though nine times in ten you succeed in referring them to the same person whom the secretary or receptionist tried to have them see in the first place. This preserves the hospital's reputation. It makes a visitor feel good that he came and that you saw him. It satisfies his ego. Now he cannot even gripe as loudly or as vehemently as he could before he saw you—and this neutralizes his potential to build up resentment against the hospital. If he felt charitable toward the hospital in the first place, his visit increases this feeling. It's a simple one-two relationship.

***Salute the Students:***

One valuable public relations asset is the flow of students who linger awhile in the hospital to further their education, then pass on to the community: affiliate student nurses, psychology students, psychiatric social workers, and residents. Enthusiastic, impressionable young people most of them are—they gain a lasting impression of the hospital, its problems, and the attitudes of the staff, and they accept an ideal vision of what it should be. Many such students will spend their lives working in the geographic area served by the hospital. To them the public will turn for information when mental illness strikes. They often become civic leaders, exerting their influence in shaping the mental health attitudes and the attitude of their community toward tax appropriations. The foresighted administrator will strive diligently to establish his educational program on a high level, for it will provide another means of evoking that prized statement of public approval: "That's a *good* hospital."

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# CALL ME MISTER

**by Dr. Whatsisname***

OUT OF HIS WARMTH and affection a physician—or other staff member—might call a patient by his first name. "How are you today, Molly?" seems so much pleasanter than the more formal, "How are you today, Mrs. Auchinschloss?" Since we want the patient to feel comfortable with the staff, the first name would appear to be a simple amiable way of doing it.

*But is it?* Aside from the family-and-friends circle, first names are associated, in our culture, with patronage and inferiority, unless the first names are used reciprocally. To call the bootblack "Joe" and the elevator attendant "Mike" is to patronize him. It is not a token of easy familiarity among equals, unless the first-name moves to a two-way street. Sometimes, between attendants and patients, first-name calling may be reciprocal. But no patient calls by his first name a staff employee who is at professional level. The unilateral use of the first name, no matter how tenderly uttered, is a symbol of inferiority status. And this is not the status we want to stress in relation to hospital patients.

The last name without the "Mr." is an even curter badge of inferiority. To address Eugene Morgan as "Gene" is patronizing. To call him "Morgan" is insulting. To call him "Mr. Morgan" no matter how deteriorated or confused he may be—is to enhance his dignity and salute his individuality. *Why should we do less?*

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*Do you agree with Dr. Whatsisname? Does his opinion hold good for the therapist who finds himself in a parental role with the patient? In such a case, might not the use of the first name reinforce this role?*

**(By the way, Dr. Watsisname is a little embarrassed by this nom de plume. He says that when you refer to anyone as "old Whatsisname" you imply a certain lack of respect, and while you may disagree with our friend, he would like you to respect his right to be controversial. He is still waiting for someone to name him.)*

*No. 2 in a Series on Mental Hospital Administration*

# REHABILITATION FOR THE MENTALLY ILL

## The administration, staffing pattern, management, and control of rehabilitation, re-education, and job placement services

By PETER A. PEFFER, M. D., Manager
Veterans Administration Hospital, Brockton, Massachusetts*

**This VA program is presented as one plan which has wide acceptance in carrying out the aspect of hospital administration designated by the Committee on Certification of Mental Hospital Administrators by the above sub-title. The function carried out by this plan may be fitted into the special organization pattern of any mental hospital and its particular resources.**

ALL HOSPITAL EMPLOYEES should participate in the rehabilitation process. This includes administrative, maintenance, custodial, and other personnel as well as the professional staff. Our basic goal in treating the hospitalized psychiatric patient is to reintegrate him ultimately into the community at the optimal level at which he is capable of functioning. The entire resources of the mental hospital community must be called into play to accomplish this aim. Likewise, the community surrounding the mental hospital must be properly prepared to accept its citizens when they are able to return to the community.

A well-organized progression of rehabilitation is essential; i.e., clearly defined levels of treatment by which we can judge the patient's progress at any particular time. Rehabilitation activities must be integrated with the overall treatment program.

The hospital's functioning should be geared to produce a situation of flexibility where the problem of first treating the sick patient and then aiding him to make the transition from the hospital to the community is of prime consideration. Administration should be focused around facilitating this process, rather than being restrictive in such instances as handling questions regarding competency, guardianship, release of funds, and restoration of drivers' licenses.

Development of an integrated rehabilitation program under the leadership of the Chief of Physical Medicine and Rehabilitation (M.D.) with a detailed master schedule of activities for each ward is necessary. This insures that patients receive the full benefits of available treatment and participate to the limit of the resources provided by the hospital. A variety of work, recreation, play, and spiritual activities should be provided. *It is essential that no patient remain idle.*

Good communication facilitates rehabilitation treatment. Written reports on patients from all personnel are made for the psychiatrist and the treatment teams on the wards. Information is passed on from the treatment team to the employee supervising the patient. There is a continual feed-back of information from the employee to the treatment team. This procedure is coordinated here by the Chief, Industrial Therapy Section and by the Vocational Counseling (Psychology) Service. It is essential that the employee (be he plumber, baker, or janitor) working with the patient be briefed in an appropriate manner. He in turn writes his own evaluation of the patient's work and social adjustment for the team.

### Staffing Patterns

The reader will recognize that the psychological, physiological, social, vocational, and economic components defined in maximum rehabilitation of the individual patient are shared by all disciplines and all employees. It is necessary to have adequate staffing to accomplish this goal. Since the writer considers that the Veterans Administration Hospital, Brockton, Massachusetts, represents an ideal from the point of design, equipment, philosophy, and staffing the rehabilitation process will be projected on that background. The staffing pattern at Brockton is a good example of adequate staffing with 1034 employees to service 948 patients (170 of whom are neuropsychiatric-tuberculous cases). Under the direction of each psychiatric ward team and the respective service chiefs, the departments below are directly associated with rehabilitation and restoration procedures involved in the patients' successful community adjustment. At this hospital the psychiatric team functions as such and on each ward there is a psychiatrist, clinical psychologist, psychiatric social worker, part-time vocational (counseling) psychologist; psychiatric nurse and psychiatric aides.

*Social Service:* The staff of this department carries on in-

* *These ideas are drawn from the writer's experiences in managing several VA hospitals. He acknowledges with sincere appreciation the very large contribution to this paper made by Dr. Bernard Stotsky, Chief, Vocational Counseling (Psychology) Service; Dr. Reuben Margolin, Counseling Psychologist (Member-Employee Supervisor); Mr. Charles Scully, Executive Assistant, Physical Medicine and Rehabilitation Service; Mr. J. Frederick Glynn, Chief, Social Work Service; and Mr. Charles Lyons, Chief, Special Service.*

tensive casework with patients and relatives beginning at the time of admission and continuing until the patient is placed on trial visit. It operates on the Acute and Continued Treatment Services and supervises the Foster Home Cottage on the hospital grounds. A unique system of follow-up in cooperation with Veterans Administration Regional Offices staffs is in effect. An effective community education and supervisory program in connection with foster home placements is also carried on. These many programs involve sixteen social workers in all areas within and outside the hospital.

*Vocational Counseling (Psychology) Service:* This is a relatively new service in the Veterans Administration which may not be familiar to those working in state and other hospitals. Because of need, the Veterans Administration has developed psychologists who are given a background of training in clinical psychology and also in vocational counseling. This service contributes greatly in uncovering the pre-vocational potential of each patient through scientific testing and counseling methods, so that realistic, long-range rehabilitation goals may be established by each psychiatric team. The vocational psychology staff provides occupational information and works through plans connected with prospective jobs for patients, evaluating the mental and physical demands of such jobs in relation to patients' abilities.

Good public relations are consistently employed in selling the "emotionally handicapped" to employers. A psychiatric industrial seminar is held bimonthly at our hospital with 12 to 15 industrialists or employers invited for an entire day. The day is spent in two-way discussion, lectures, and tours so that employers will have an understanding of the mental patient and his potential as a prospective employee.

Intelligent follow-up services are carried out by this staff to help the patient during his transition from hospital industrial therapy responsibilities to gainful employment in the community. For rehabilitation cases who are readmission problems, or who demonstrate a need for realistic work and socialization conditioning within the hospital structure, a patient-employee program (called Member-Employee Program) is in effect at Brockton. Kind, understanding, but firm supervision of member-employees is administered by the counseling psychology staff. Its consultative services are fully utilized by Physical Medicine and Rehabilitation therapists in gearing activity therapies to meet the emotional, preeducational, and prevocational needs of each patient. Staffing is covered by six vocational psychologists.

*Special Service:* Recreation, adapted sports, music, library (general and medical), and volunteer activities comprise the major units of this service. (The Special Service team is a carry-over from the Army which had units covering the above-mentioned activities. Since these activities are so essential in the rehabilitation of mental patients, the Veterans Administration has set up these activities under the same title.) The activities of this department are structured to coincide with the overall rehabilitation process, including recreational and social experiences for acutely sick patients who need the

protective setting of closed ward groups. Higher levels of activity are provided for partially or fully privileged patients. Resocialization is fostered as the primary goal. Avocational interests and development of good leisure-time habits are the long-range goals to insure the successful post-discharge adjustment of the patient. The staffing pattern is as follows: one chief, three librarians (one medical), six sports technicians (one female), one director of volunteers, one recreation director, one recreation technician, one projectionist, one music therapist, and one radio and drama therapist. There are 425 regularly assigned volunteers and a large number of occasional volunteers also help to make this program effective.

*Chaplaincy Service:* Two full-time and three part-time chaplains representing all faiths are assigned to the hospital to provide spiritual care to patients, and to advise and counsel relatives coming to the hospital.

*Canteen Division:* This department serves in the rehabilitation process by offering realistic shopping opportunities covering a wide range of clothing, food, and confectionery. A fully equipped haberdashery allows for selection of all items of clothing. Saturday mornings are devoted to this clothing project when patients are taken to the shop by psychiatric aides to make their own selections. Ward team members who accompany the more regressed patients may assist them in making selections.

*Physical Medicine and Rehabilitation Service:* Six specialized therapies comprise this service which is headed by a physician trained in the application of its many modalities and fully oriented to the ramifications of psychiatric rehabilitation. The wide diversity of treatment media, techniques, goals, operational and administrative procedures make it essential that these units be coordinated with the physician in charge by a rehabilitation specialist (layman), possessing the time and experience in areas of medical administration and overall rehabilitation planning—e.g. staff coverage, program planning, patient interviewing, and case follow-ups. Staff distribution, in addition to the above, is as follows: Physical Therapy—one chief and two therapists; Corrective Therapy—one chief and seven therapists; Occupational Therapy—one chief, nine therapists, and one aide; Educational Therapy—one chief and four therapists; Manual Arts Therapy—one chief and five therapists; and Industrial Therapy—one chief and ten technicians, making a total of 49 positions in this service.

### Management and Control of Rehabilitation—Re-Education and Job Placement Services

Rehabilitation activities are graded in levels. For the more regressed patient, activities which incorporate simple work and social situations are provided. Here, accomplishment and achievement are easily experienced. In Occupational Therapy the emphasis is on encouraging socialization, stimulating creative impulses, and satisfying therapeutic needs through the medium of arts and crafts. In Corrective Therapy, exercise as a treatment agent is used to satisfy the same therapeutic needs. Individual and small group physical activities are utilized to stimulate the regressed and withdrawn patients to express themselves at a non-verbal motor level. As the patient progresses he is placed on Adaptive Sports under Special Service where he participates in formal, competitive athletic games. Here he is less protected and given less individual attention than in Corrective Therapy. Group Therapy discussions for educational purposes are utilized to encourage resocialization, greater orientation as to time, place, date, and events, and participation in the more verbal activities. The crux of rehabilitation therapy at the less advanced level is for the development of interpersonal relations. All hospital personnel share in this. All staff are alerted to observe improvement.

Following improvement the patient is given more responsibility; first, work privileges; later, full grounds privileges and extramural passes as he is ready for them. He may be placed in a simple level industrial assignment such as caring for the grounds, landscaping, or helping in the kitchen, or receive intensive, individual instruction in Educational Therapy (bookkeeping, office work, course work, etc.) and Manual Arts Therapy (machine shop, auto repair, light mechanics, graphic arts, drafting, electrical work, woodworking, and furniture repair) following psychiatric and vocational evaluations, psychological tests, and counseling. The next step is to place him on full-time, individual industrial assignment with full grounds privileges and few social restrictions. At this hospital at present there are 200 patients on individual work assignments and 200 on group industrial assignments. Almost half of the patient population is working in job situations. Some of them are of a higher technical nature such as auto mechanic, locksmith, dental technician, draftsman, cost estimator, IBM clerk, and plumber. Patients understand that their ability to handle privileges is associated in the minds of the staff with their work performance; the two go together.

Let us use one progression as an example of how rehabilitation works: During a regressed phase, the patient will go through Corrective Therapy, Occupational Therapy, and Educational Therapy, with assignment in Occupational Therapy including an industrial assignment in the ceramics workshop for which he receives compensation. As the patient improves he may, following vocational assessment, receive individual instruction in auto mechanics in Manual Arts Therapy. After instruction is completed, he will go on an individual assignment as a mechanic helper in the garage. This is the highest level he can reach as a patient within the hospital. As he improves, emphasis is placed on productivity at a level approaching that which is expected of a worker in the community. The patient's supervisor becomes less permissive. The next step involves intensive activity by the psychiatric team with respect to planning the patient's return to the community. Efforts are made by the vocational psychologist and the psychiatric social worker to assist the patient to work out problems with his family, obtain housing, and secure employment.

The following programs are utilized to effect satisfactory transition to the community:

a. *Trial Visit:* In this program patients are returned to their homes after reasonable casework goals have been set. The goals are worked through with the Veter-

ans Administration Regional Office social worker who participates in pre-discharge planning at the hospital with the therapeutic team, and these regional office workers follow the patients while they are on trial visit.

b. *Foster Home:* Patients not requiring the specific care of the mental hospital, who cannot return to their own homes, are encouraged to live with foster parents in the community. As a rule, no more than two patients are placed in one home. This is done to insure individual care and a family-type situation.

c. *Cottage Plan:* This plan, still in the trial stage, involves the placement of selected patients with low employment potential, due to disabling physical condition or advanced age, in a small cottage on the hospital grounds. The cottage has a foster mother (a hospital aide) and a foster father to provide as nearly as possible the atmosphere of home and community. The patients learn through doing how they can utilize their day. They prepare some portion of their meals, serve their own meals, wash dishes and cooking utensils, clean their own rooms and the cottage, keep the area outside of the cottage tidy, trim shrubs, and cut grass. They have a garden adjoining the cottage and are free to select, plant, and raise the vegetables and flowers of their choice. Avocational hobbies are taught and utilized. These patients are helped in relearning niceties of etiquette and personal cleanliness. This program conditions them for later community placement in a foster home and demonstrates to the families of patients, or to prospective foster mothers, that the patient can adjust outside of a ward in a mental hospital.

d. *Member-Employee:* This program, as espoused by the writer, involves taking the patient on as a salaried employee of the hospital. He is discharged from patient status, is regarded as an employee, assumes full work responsibility, receives no supervision after duty hours, has full personal liberties, and is expected to conform to the work regulations covering Federal employees. After a period on the program he is placed on a job in the community; continued follow-up is carried out. Within the Veterans Administration several hospitals have worked out an exchange plan whereby stations exchange member-employees on a one-for-one basis in order to take them as regular employees. (A valuable adjunct to this plan, as described elsewhere by the writer, is that when the patient seeks outside employment, he already has a "work record." Ed.)

e. *Direct Vocational Placement:* Some patients leave the hospital and go directly into jobs in the community. This is accomplished through job placement by the vocational counseling psychologists. These patients are followed up on the job to assist them in adjusting to the new situations. A night-or-day hospital relationship may be followed in selected cases.* (In other words, a patient may live in the hospital at night and work in the community during the day, or he may live in the community at night and work as an industrial therapy patient or member-employee at the hospital during the day. These are steps which are at times absolutely necessary in getting a patient out into the community; since some patients can only make it out a step at a time, we give them assistance in taking the step). In addition there is a cooperative agreement with the Division of Employment Security regarding referral of patients for jobs.

**Comment**

The writer may appear to have painted an unrealistic picture as far as rehabilitation, and even as far as the overall functioning of a mental hospital is concerned. However the Federal Government has endeavored with the Brockton VA Hospital (and other similar hospitals) to prove a point; that is, if the hospital had the latest architectural advances built into it and was properly equipped and staffed, this should lead to the rehabilitation of a greater number of patients. The writer is of the firm conviction that this effort has proved its value and that we, as psychiatrists, and those in allied professions in mental hospitals, should not be content until we have the means to accomplish our treatment aims. He is of the firm belief, based on experience, that there is no cheap way out in the care, treatment and rehabilitation of the mentally sick patient; that illness of whatever type requires an almost equal expenditure of money. We should not be content to see mental hospitals receive ridiculously low per diems when we know that we now have available the necessary treatments and rehabilitation techniques to approximate the results obtained in the treatment of any other diseases.

* *(This arrangement of living in the hospital while working in the community, or vice versa, is primarily a supportive measure, and is not to be confused with the "Day Hospital" and "Night Hospital", which have other very specific functions. Ed.)*

## SK&F Fellowship Deadline April 1

April 1 is the deadline for applications for the Smith, Kline & French Foundation Fellowship grants to be considered by the Fellowship Board when it meets May 1. The Board hopes to award from six to twelve more Fellowships at that time. Grants will generally not exceed $600 a month, but will vary according to individual situations. The Board announces that both U. S. and Canadian citizens are eligible, although the projects must be carried out in the United States. Application blanks and full details are available from the offices of the A.P.A.

Pictured at right are the two psychiatrists who were awarded the first SK&F Fellowships. Dr. George W. Brooks, of Vermont, is now studying advanced methods of diagnosis and treatment at the Boston Psychopathic Hospital. Dr. Denis Lazure is spending eight months at the Child Study Center of the Institute of the Pennsylvania Hospital, in Philadelphia, studying the psychotherapy of children and the functioning of a guidance clinic.

Dr. Brooks

Dr. Lazure

# THE PATIENT DAY BY DAY

## Patients Conduct Educational Courses

The Helping Hand Society, a patients' organization at N. J. State Hospital at Greystone Park, is holding a series of educational classes taught by the members themselves. Three classes a week are scheduled, and are held in a ward dining room, which is equipped with a blackboard for the purpose.

Course content is derived from the practical experience of the patient-instructor. One member, a former English instructor, teaches a refresher course in grammar, composition and literature. Another former teacher is giving instruction in mathematics. The third class currently being held concerns the study of trees, taught by a member who was a tree surgeon prior to hospitalization.

Topics under consideration for future classes include Salesmanship, to be taught by a former salesman, and Photography, which is to be given by a member whose hospital work assignment is with the hospital photographer.

Materials from the local library are used as teaching aids, along with any from the instructors' home libraries which their relatives bring when visiting.

## Central Shoe-Fitting Dept. Results in Comfort, Economy

The establishment of a Central Shoe-Fitting Department in the Shoe Shop at Metropolitan State Hospital, Norwalk, California, is resulting in increased comfort for the patients, and in greater efficiency and economy for the state.

The previous practice of keeping a stock of new shoes on each ward has been discontinued with savings in time and personnel formerly needed to maintain inventory. "Dead" shoe stock no longer takes up space. More important, no patient is handed a pair of shoes which "look as if they would fit."

Patients are now sent or taken to the new department to be properly fitted. Any real foot difficulty is noted and the patient referred to the Department of Chiropody.

Proper fitting makes it possible to maintain more efficient sizing. Fewer pairs of shoes are issued. Comfortably fitted, the patient is less inclined to destroy or "lose" a pair of shoes in the hope of getting a more comfortable pair. Patients report that their minds are off their feet, that they are consequently less distracted and better able to respond to rehabilitation.

VERNON W. WIER, D.S.C.
Chiropodist

## State School Trains Parents As Pre-admission Counselors

Ten parents of patients at Polk (Pa.) State School were chosen to serve as counselors of parents whose children are on the school's waiting list. A two-day course of intensive training for the counselors was held under the school's auspices in January. They will work from offices in downtown Pittsburgh which were set up by the Pittsburgh chapter of Friends of the Mentally Retarded. Scheduling of the counseling interviews is arranged by Polk State School. For the present the service will be limited to parents who have already filed application for their child's admission to Polk.

## Anonymity Ceases in Hospital Publication

Patients who contribute to the current issues of POMO NEWS, the Mendocino (Cal.) State Hospital paper, no longer use such by-lines as Mary B. Instead their full names are given.

"This is a milestone in the progress of the hospital and in the general understanding of the nature of mental illness," says Dr. Daniel Lieberman, the superintendent. "Patients contributing to this paper are proud of the fact that they are overcoming their mental disorder, and do not hesitate to tell the world that they will soon be prepared to resume their places in society, having overcome an affliction that affects tens of thousands of people in this country every year."

Those who attended the Seventh Mental Hospital Institute will recall the heated discussion which took place about the "masked faces" of mental patients in photographs.

Dr. Lieberman's report indicates that other barriers too are tumbling.

## Patient-Panels Discuss Mental Health Films

At California's Metropolitan State Hospital, Norwalk, patients are invited to showings of mental health films. Their relatives may attend also, if they wish, and the audience sometimes numbers as high as 300 people.

A staff member introduces the film briefly, raising points which might be considered in watching the picture. After the showing, a panel of patients takes the stage to discuss their reactions to the film. One of the patients acts as chairman, and the audience is invited to express opinions and raise questions.

The hospital says that the discussions become quite spirited at times, for the acceptance displayed by the staff members present allows the patients to feel free to express differing views.

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## Art Contest Open to Mental Patients

Occupational Therapists may be interested in the National Art Contest for the Handicapped, sponsored by the Vocational Rehabilitation Dept. of the Dept. of Health, Education & Welfare, the President's Committee on Employment of the Physically Handicapped, the Veterans Administration and the Morris Morgenstern Foundation.

This contest is open to the mentally ill and to the mentally retarded. Only original work done by the patient in *oil, water color, gouache or tempera,* on canvas or paper is eligible, and each contestant may send only one entry. The closing date for entries is May 1st, 1956.

Announcement forms containing details may be obtained from A.P.A. Mental Hospital Service, and further information from The National Art Contest for the Handicapped, % Morris Morgenstern Foundation, 119 West 57th Street, New York N. Y.

Over 20 substantial cash prizes, ranging from $1,000 to $50 are offered; first, second and third winners able to travel will receive their prize money at an appropriate ceremony, probably in Washington, D. C.

# DEPARTMENTS

## Hospital Pharmacist Effects Economies

Several months ago, Western State Hospital, Hopkinsville, Ky., hired a pharmacist on a half-time basis. Within a few weeks the new pharmacist had weeded out of stock over $1680 worth of outdated and obsolete drugs, which were returned to the various drug companies in exchange for drugs which were needed. Most of the drug companies were most cooperative, and the exchange program has been put on a continuing basis.

Since the hospital's drug room is open only while the pharmacist is on duty, he made up an emergency medications kit, which is kept in the minor surgery room. Other innovations are planned for the near future. These include standardization of stock medicine bottles, more rigid control of purchases, testing of the effectiveness of disinfectants and deodorants, and initiation of controls to curtail excessive use of drugs.

## New York Opens Third Aftercare Clinic

The opening of the third of four centralized clinics to provide aftercare for mental patients from the New York City area has been announced by Dr. Paul H. Hoch, N. Y. State Commissioner of Mental Hygiene. This Clinic is located at Jamaica, Long Island.

Like the other clinics already established in Brooklyn and the Bronx, the Long Island clinic will provide psychiatric and social services to patients on convalescent care. Dr. Eugene B. F. Riley, formerly of Creedmoor State Hospital, is the psychiatrist in charge, and Miss Josephine V. Cooper, from the same hospital, is the supervisor of social work.

The new clinics—the last is to open in Manhattan—replace those formerly conducted by individual state institutions. Dr. Donald M. Carmichael is director of the aftercare program of the Dept. of Mental Hygiene.

## Student Nurses to Work With Retarded in N. Y.

Student nurses from two New York state hospital schools of nursing are being given clinical experience in nursing of the mentally retarded as part of their regular curriculum. The four-week course, given at the senior level, is conducted at Willowbrook State School, Staten Island.

The first group of students, from Pilgrim State Hospital, took the course during January, and the second class is now underway with a group from Kings Park State Hospital. The Department of Mental Hygiene expects to extend the program to its other schools of nursing in the near future.

The training at Willowbrook includes working with patients on the admission services, rehabilitation and training wards, and in the education department.

In addition, the student nurses are assigned to observe home visits, colony care centers, public school classes for the mentally retarded, and social agencies which work in the field of mental deficiency.

# News & Notes

## Dr. O'Neill Named Secretary of Certification Committee

Dr. Francis J. O'Neill, Director of the Central Islip (N.Y.) State Hospital, has been appointed Secretary of the A.P.A. Committee on Certification of Mental Hospital Administrators. Dr. O'Neill replaces the late Dr. Crawford N. Baganz.

The Committee's next meeting to examine candidates for certification will be held on April 28 at the Morrison Hotel in Chicago, just prior to the A.P.A. Annual Meeting.

## Sen. Hill Honored

The National Mental Health Committee has conferred its first annual award upon Senator Lister Hill, of Alabama, for his contribution to the fight against mental illness. Senator Hill received a statuette and a citation.

The citation noted that he sponsored the legislation creating the National Institute of Mental Health and has fought for increased appropriations to enable the Institute to expand its research and training grants. The citation also praised Senator Hill for introducing the Mental Health Study Act of 1955 and the Hill-Burton Act of 1946.

## Symposium Held on "Problems of the Mind In Later Life"

A one-day symposium on "Problems of the Mind in Later Life" was held January 12 in Cincinnati, Ohio, under the sponsorship of the Wm. S. Merrell Co., pharmaceutical manufacturers. The attendance of approximately 200 included a number of physicians, psychologists and nurses who work in mental hospitals.

The program was moderated by Dr. Maurice Levine, Professor of Psychiatry at the University of Cincinnati College of Medicine. Dr. Levine keynoted the meeting by saying that it would consider both the somatic and psychotherapeutic aspects of geriatric medicine approached on a "statesmanlike" basis to reconcile the two, and not viewed as an "either-or proposition."

The speakers were Dr. Karl Bowman, San Francisco, Calif.; Dr. Franklin Ebaugh, Denver, Colo.; Dr. Edward Weiss, Philadelphia, Pa.; Dr. George N. Raines, Washington, D. C.; Dr. Freddy Homburger, Boston, Mass.; Dr. Ewald Busse, Durham, N. C.; and Dr. Edward J. Stieglitz, Washington, D. C. Their topics covered such aspects as social and psychological stresses; cardiac and other medical disabilities which have psychosomatic implications; and even adolescence—as a predictive pattern for future problems of aging.

## Reiss Pavilion Opens

On January 28th, the Jacob L. Reiss Mental Health Pavilion of St. Vincent's Hospital was officially dedicated by His Eminence Francis Cardinal Spellman, Archbishop of New York. Its director is Dr. Harvey J. Tompkins, one of the Mental Hospital Service Consultants and formerly Chief of Psychiatry and Neurology of the Veterans Administration.

This psychiatric pavilion, in the heart of Greenwich Village, is designed, equipped and staffed for short-term hospital treatment. In addition to its 97 beds, extensive outpatient services are also provided.

Other speakers included Dr. Francis J. Braceland, President-Elect of the A.P.A.; Mr. Raymond H. Reiss; Dr. Hayden C. Nicholson; the Honorable Robert F. Wagner, Mayor of the City of New York; and the Honorable George B. De Luca, Lieutenant Governor of the State of New York.

# People & Places

**Dr. V. Terrell Davis** was named Director of Mental Health for the N. J. Dept. of Institutions and Agencies, succeeding **Dr. Edward N. Pleasants.** Dr. Davis previously was Asst. Director of the Wisconsin Division of Mental Hygiene. . . . **Dr. Joseph Bounds,** formerly manager of the VA Hospital, Jefferson Barracks, Mo., is now manager of the VA Hospital at Roanoke, Va., succeeding **Dr. Charles W. Grady,** who retired. . . . **Dr. Hubert Fockler** was appointed Superintendent of Athens (Ohio) State Hospital; he previously was Asst. Superintendent. . . . **Dr. Howard Fiedler,** formerly Superintendent of the Retreat (Pa.) State Hospital, now Superintendent of Allentown (Pa.) State Hospital. . . . **Dr. Richard L. Harris,** Manager of the F. D. Roosevelt VA Hospital, Montrose, N. Y., died in November. . . . **Dr. Carl Catlin** has succeeded Dr. Norman D. Render as Superintendent of the Clarinda (Iowa) Mental Health Institute; he previously was Asst. Superintendent. . . . **Mrs. Dorothy Hall** was appointed Director of Nursing at Eastern State Hospital, Vinita, Okla. . . . . **Mr. George Edward Shipferling** has resigned as Director of Food Services for Mental Hospitals, State of Maryland, to become Asst. to the President of the H. R. Nicholson Co., manufacturer of citrus fruit juice bases. . . . **Mrs. Doris May Trobaugh** was appointed Director of Nursing Education at Osawatomie (Kans.) State Hospital. . . . Radio-TV Station WHAS in Louisville, Ky., selected as "Men of the Year" in the Kentucky-Indiana area served by the station, **Dr. Frank Gaines,** Director of the Kentucky Dept. of Mental Health and **Dr. Margaret Morgan,** Commissioner of Mental Health for Indiana, along with Brooklyn Dodger player Harold "Peewee" Reese, who makes his home in Louisville.

# M. H. S. News & Notes

## New A.P.A. Publications

### A.P.A. School Standards Available

Standards for the Organization and Operation of Hospitals and Schools for the Mentally Defective, prepared by the A.P.A. Committee on Standards and Policies of Hospitals and Clinics, with the cooperation of the American Association on Mental Deficiency, have been approved by the Executive Committee of the A.P.A. Council, and are available from M.H.S.

The 56 page book, bound in two shades of blue, includes Parts I, II and III of the Standards revised in 1954, governing the operation of public and private psychiatric hospitals, and psychiatric units in general hospitals. The price remains the same—75¢ a copy.

The Committee, under the Chairmanship of Dr. Harvey J. Tompkins, has started work on Part V—Standards for the Organization and Operation of Psychiatric Outpatient Clinics. An

announcement will be made when this section is ready for publication.

### Two Special Publications

Copies of GROUP THERAPY IN THE MENTAL HOSPITAL, by Jerome D. Frank, M.D., are still available at 50¢ a copy. This is No. 1 in the Monograph Series published by A.P.A. Mental Hospital Service. Additional copies of the special February issue of MENTAL HOSPITALS, containing substantive accounts of the Proceedings of the Seventh Mental Hospital Institute, are also available at 50¢ each.

## Loan Library Additions

Please enclose 10¢ for each one pound volume and 14¢ for each two pound volume to cover postage and handling.

#### WARD MANUALS AND TRAINING OUTLINES

**Instructor's Guide—In-Service Training for Food Service** compiled by Institution Food Administrators Training Committee (Calif. Dept. Mental Hygiene) 1 lb.

**A Guide to Hospital Social Work for New Physicians, Residents and Other Personnel** (prepared by the Soc. Serv. Staff, NP Hospital, VA Center, Los Angeles, Calif.) 1 lb.

**Teaching Manual for Affiliate Student Nurses** (Metropolitan State Hospital, Norwalk, Calif.) 1 lb.

**Physicians' Manual** (Patton, Calif., State Hospital) 1 lb.

**Staff Manual for Patients' Library** (Napa, Calif., State Hospital) 1 lb.

**Resident Training Program in Psychiatry** (Trenton, N. J., State Hospital) 1 lb.

**Third Year Residency Training Program in Psychiatry** (Trenton, N. J., State Hospital) 1 lb.

**Revised Program Affiliate School of Nursing** (Trenton, N. J., State Hospital) 1 lb.

#### MISCELLANEOUS

**Draft of Interstate Mental Health Compact** (Northeast State Governments Conference on Mental Health) —Council of State Governments, NYC 1 lb.

**PBX Procedures** (Patton, Calif., State Hospital) 1 lb.

**Standard Specifications for Meat, Meat Food Products, Lard and Shortening** (Kansas State Dept. of Administration) 1 lb.

## 8th Mental Hospital Institute to Meet in Denver

The Eighth Mental Hospital Institute will be held October 8-11, 1956, in Denver, Colorado, at the Shirley Savoy Hotel.

Dr. Lucy D. Ozarin, Chief of Hospital Psychiatry, Veterans Administration, has been named as Chairman of the Program Committee for the Institute. The other members of the Committee are Dr. Granville Jones, Superintendent of Eastern State Hospital, Williamsburg, Va., who is a Consultant to Mental Hospital Service, and Mr. Alexis Tarumianz, Business Manager of the Delaware State Hospital, Farnhurst.

The Local Arrangements Committee is being co-chaired by Dr. Herbert S. Gaskill, Chairman of the Department of Psychiatry of the University of Colorado School of Medicine, and Dr. Frank Zimmerman, Superintendent of the Colorado State Hospital, Pueblo.

# SCIENCE WRITERS EXAMINE PSYCHIATRIC RESEARCH

## Tour of Research Hospitals Emphasizes Clinical & Basic Investigations

Everybody connected with psychiatry, and perhaps especially hospital people, is familiar with the criticism that psychiatry is "unscientific"—unable to prove its hypotheses.

During the last week in January, the National Mental Health Committee conducted a four-day tour for some 25 science writers from newspapers, magazines and wire-services through five psychiatric research centers—the National Institute of Mental Health, Bethesda, Md.; Galesburg Research Hospital, Ill.; the Allan Memorial Institute of the Royal Victoria Hospital, Montreal and the Montreal General Hospital; and Rochester State Hospital, New York.

These writers, whose job it is to educate and inform the public on new scientific developments, can do much to demonstrate that, as Dr. S. Jacques Gottlieb said, psychiatry can now begin to test its hypotheses, both in the laboratories of the biological sciences and by testing techniques developed by psychology and the other behavioral sciences.

Dr. Gottlieb, Chairman of the A.P.A. Committee on Research, accompanied the group to explain, interpret and answer questions on all psychiatric matters. Smith, Kline and French Laboratories of Philadelphia paid the expenses of the trip.

"Psychiatry, as it is practiced today, is merely the application of hypotheses," said Dr. Gottlieb, in his orientation talk at the beginning of the tour. "But today, experimental psychiatry at last has a home. Philosophical concepts come first in any field. It is the function of objective science to correct or support these concepts."

He emphasized that mental illness is not a single entity. Today all sorts of disorders are considered under this heading, ranging from the frank psychoses through the psychoneuroses and including the psychosomatic disorders and emotional disturbances which are a part of somatic illnesses.

At the National Institute of Mental Health, the Federal Government's mental health agency, the emphasis, according to the Director, Dr. Robert H. Felix, is mainly on basic research. Multi-disciplinary workers – sociologists, psychologists, physiologists, biochemists, anatomists and others—are making studies of both normal and abnormal individuals in an attempt to adequately control all their investigations in the fields of action, feeling and thought, and somatic manifestations in adults, the aged and children. Both human and animal research are employed.

Among the clinical investigations presented were studies on the emotional difficulties of children, carried out in a residential setting; goals are to determine the most effective methods of operation for such treatment centers, and the kind of activities that are the most therapeutic; other goals are to learn about the nature of group excitement, which kind of person should work with such children and what types of children can benefit from such a setting; investigators are also seeking how to make a rapid, early and accurate assessment of the specific nature of children's difficulties before they become major problems.

The Family Study Unit is trying to find out what goes on between parents and children in families in which one of the children becomes mentally ill, with the hypothesis that this study may provide clues as to what went on during the early years of the patient, who is viewed as a member of an impaired family group.

### Aging Processes Studied

The aging process is being investigated in relatively normal men over 65, using a 2-week work-up, including psychological testing, psychiatric and medical examinations and study of cerebral blood flow. In psychological studies, two groups of humans and one group of rats are having their reaction times measured in relation to aging. This section's physiological studies are focussed on the biological properties of the aging nervous system.

In the same clinical laboratory, a comparative drug study is going on, comparing the effects of barbiturates, lysergic acid diethylamide, chlorpromazine and demarol. This study, as well as a study of the endocrine system and the ways in which the brain affects endocrine action, utilizes normal young volunteers. Another investigation is a study of the various types of interaction, especially verbal, on a ward of adult schizophrenics.

Laboratory investigations demonstrated included work on the fundamental problems of the nervous system, its patterns of activity and the metabolic relations involved. Electrical stimulation is used to study oxygen tension and oxygen consumption in the cerebral cortex.

The Laboratory of Neurophysiology is studying the mechanisms of interaction between the brain and neurons in the spinal cord. The Section on Cortical Integration is attempting to trace patterns of electrical activity across the cerebral cortex as an accompaniment to voluntary action and in response to stimuli.

At Galesburg Research Hospital, there is extremely close integration between the clinical and basic research programs. Studies on the site of action of new drugs—chlorpromazine, reserpine and others still on the secret list, were described by Dr. Lester Rudy, Superintendent, and Dr. Harold E. Himwich, Research Director. Papers have already been published on brain metabolism in relation to aging; an analysis of the acti-

vating system, including its use for screening drugs to treat Parkinsonism and the clinical evaluation of azacyclonal (Frenquel), chlorpromazine and reserpine on a group of chronic psychotic patients.

The site of action of the new drugs is being studied, as is the blocking action of some of them on the reticular formation. Studies on rats indicate that reserpine and chlorpromazine in therapeutic doses will retard learning, and increase food intake under certain conditions. Another hypothesis being investigated is that mental aberrations may be associated with abnormalities of serotonin metabolism. The effects of atropine sulfate on the central nervous system is being studied in college students who were injected intramuscularly with from 2 to 10 mg. of atropine—electrical brain waves were affected, and a significant loss of muscular coordination was noted. The blood brain barrier and how its permeability may be influenced is the subject of another study.

A clinical study called the Metabolic Wards Program is investigating the effects of aging through repeated biochemical, physiological and psychological tests. This study, carried out under controlled conditions of diet, activity and therapy enables researchers to use long-term observation of the same person for the total span of his later years. A ward of high-grade mental defectives is used as a control group for a ward of schizophrenics to study the much postulated but never proven metabolic difference in schizophrenia.

### Psychological Investigations

At the Allan Memorial Institute, investigations seen were mainly in the area of psychological and sociological sciences, although the new drugs are being investigated, and important work is taking place in neurochemistry, neuroendocrinology and electrophysiology. Electroencephalographic findings in the functional diseases are being studied in the electrophysiological laboratory, and results indicate that EEG may be used to differentiate neurotic from psychotic depressive reactions. The gerontological unit has been engaged for many years in continuous studies of the psychiatric and biological problems of the aged.

Most interesting to the visitors, however, was the "Psychic Driving" investigation being made by Dr. D. Ewen Cameron. This consists of the playback of a "loaded passage" to a patient. The constant repetition of this passage in his own voice apparently recalls more and more emotionally charged memories, and eventually establishes what Dr. Cameron calls a "dynamic implant," meaning that the patient, becoming increasingly sensitized to these memories, ruminates on them and provides still more material. It is postulated that one reason for this psychological effect is the elimination of bone-conduction of the voice, so that the patient for the first time hears his voice through sound waves only. The elimination of the bone conduction apparently evades the defense the patient has set up.

A basic investigation arising out of this consists of the electronic "breakdown" of the patient's voice, to determine if any consistent patterns emerge

which may lead to clinical clues as yet too acoustically minute for the clinician to detect. This work, said Dr. Cameron, is in its preliminary stages, but may lead to some interesting new developments.

The famous Day Hospital, described by Dr. Cameron in a chapter of Dr. A. E. Bennett's book, The Practice of Psychiatry in General Hospitals, was included on the itinerary, and visitors were also considerably interested in the Well-Being Clinic (See MENTAL HOSPITALS, April 1955, Vol. 6, No. 4), and the Discharge Group (See story in this issue on Page 24). What might be termed "administrative-clinical" studies on the follow-up of schizophrenics and manic depressives after they leave the hospital, and on the values of relatives' groups have been in progress for some time, and staff members of the Allan Memorial have generously promised MENTAL HOSPITALS papers on these activities within the next few months.

At the Montreal General Hospital, Dr. A. E. Moll, Director of the Department of Psychiatry, described his work in the Night Center. (See MENTAL HOSPITALS, Vol. 7, No. 1, January 1956). The writers were especially interested in the preventive value of this Center in dealing with pre-psychotic symptoms, and allowing patients to receive treatment without its becoming public knowledge among work-mates, neighbors and friends.

### Drug Therapy Results in N. Y.

At Rochester State Hospital, N. Y., the group saw some of the overall results of chlorpromazine and reserpine on an average hospital population. Dr. Christopher F. Terrence, the Superintendent, said that the number of disturbed patients today was about 35 or 40 compared to about 280 under similar conditions before the drugs were used. Dr. Henry Brill, Assistant Commissioner of Mental Hygiene for the State, said that approximately 25,000 patients in New York's state hospitals had completed a course of drug therapy by the end of December, 1955; 16,000 are still in therapy, making a total of 41,000 patients, out of a total patient load of 92,000, who have received chlorpromazine, reserpine or both. It is too early yet to determine statistically significant effects upon discharge and re-admission rates, but behavior and accessibility were noticeably improved in most patients.

It was emphasized that it would take many years to properly evaluate any of the new drugs, and to determine their proper function in the treatment of mental illness. Preliminary studies convince most observers that they have come to stay—another therapy in psychiatry's armamentarium. In spite of the fact that about 1% of patients, especially in the early stages of the use of the drugs, had showed complications, mainly liver disorders resulting in jaundice, the general opinion was that "these are very safe drugs."

Dr. Benjamin Pollack, Assistant Director, has prepared a paper on the changes in the mental hospital resulting from the addition of the new drugs to the total program. We hope to publish this in an early issue.

One thing seems bound to bring lasting benefit—the fact that these drugs make it possible for every public and private hospital to carry out controlled clinical studies on its own wards. The basic sciences call for specially trained people; clinical research, with the use of the drugs to make patients accessible and cooperative, calls only for keen observation, careful control and organization of results.

### Influence on Public Seen

The public relations value of this tour of psychiatry, and especially to hospital psychiatry, is apparent. The writers who went lead their field in the interpretation of scientific material to the public. Their influence within their own profession is considerable. To them, psychiatry is not just "good human interest stuff," but a science entering its second or experimental phase of development.

The public accepts the findings of the physical scientists, many of whom are deeply involved in our field. The men and women who, during this tour, have seen some of the investigative methods currently in use will help broaden public acceptance of psychiatry as a science. Meanwhile, perhaps the best service public mental hospitals can do, not only to further the development of scientific psychiatry, but also to increase public acceptance and understanding, is to assume responsibility for scientific evaluations in their own wards and laboratories—and invite the public in to observe this work.

# THE DISCHARGE GROUP

By DR. T. J. BOAG, Psychiatrist in Chg., Ambulant Treatment
and PHYLLIS POLAND, Case Work Supvr., Social Service Dept.
Allan Memorial Institute, Montreal, Quebec

"It's like home here, where you have friends. It makes me feel depressed to think that I may only be here for one more week," said one patient in the Discharge Group, expressing his feelings about leaving the hospital.

Our Discharge Group was set up to help the patients recognize and deal with some of the difficulties which arise just before they leave the hospital and the problems which they may encounter after they have returned home.

Before the establishment of the group in 1949, it was noted in individual therapy that the majority of patients showed increased anxiety as the time for discharge approached. Sometimes anxiety was so severe as to precipitate a return of symptoms. In hospital the patient is isolated from the stresses of his daily world, feels secure, and has few responsibilities, while staff members want to help him, and understand and accept him. He also makes friends with fellow patients. On discharge, he has to leave this "good home" and must again face the competition and responsibilities of the outside world. Frequently he may also fear that he is returning to a situation which precipitated his breakdown.

Anxiety aroused by discharge is difficult for the patient to understand and accept. To the extent that it is due to his intensified dependency needs fostered by his hospital stay, he does not want to recognize it, for recognition will increase his sense of inadequacy. Even after he becomes aware of his dependence on the hospital, he feels he is "the only one" there with such a degree of dependence. Only group therapy breaks down this sense of isolation.

Where such feelings are not adequately discussed, discharge is particularly liable to be experienced as a severe rejection, and consequently patients may not return for necessary follow-up treatment.

Inadequate working-through of these feelings of anxiety may also show itself in resistance to discharge, as in the patient who expresses surprise and hostility on the day of discharge although he has in fact been prepared for it. Others bring "real" reasons why they cannot leave. For example, an out-of-town patient who is to remain in the area for follow-up treatment, may be unable to find a room or when living accommodation is found, will find reasons why it is unsuitable.

Another manifestation of this anxiety is the use of mechanisms of denial with respect to the realistic difficulties that must be faced immediately on discharge, and the planning of re-establishment and rehabilitation that should take place toward the end of the hospital stay. This leads many patients to postpone these efforts until they have left the hospital so that valuable time is lost and they are not well prepared to cope with the difficulties they encounter. Such a patient will experience increased anxiety in the first week or two out of hospital, and he and his relatives become panicky, believing he is having another breakdown.

The aims of the Discharge Group are: (1) to demonstrate that the feeling of anxiety associated with discharge is universal; (2) to provide a means of fostering a positive and realistic attitude towards patients' problems of discharge and rehabilitation; (3) to discuss common problems, using group experience to find solutions; and (4) to sum up and integrate the experience and knowledge gained through therapy and apply it to the patient's everyday living.

The group meets weekly for one hour under the joint leadership of a psychiatrist and a social worker. The attitude of the leaders is generally non-directive, except to channel discussion into problems of discharge. Both leaders provide factual information when requested by the group. The social worker, in particular, tells the group about services available in the community, such as employment and social agencies, recreational and educational facilities, and so on.

Patients are invited to start attending three weeks before the expected date of discharge, and they may return afterwards if they wish. Members are carefully chosen because experience has shown that patients not sufficiently in touch with reality to be concerned with problems outside the hospital are unable to participate constructively and often disrupt the group.

As the population of the group is a changing one, at the opening of each meeting one of the older members is asked to explain the purpose of the group. This is usually effective in initiating discussion.

Topics develop spontaneously during discussion, but certain themes recur constantly from group to group. Points most frequently brought up are: (1) Should a patient be 100 per cent cured by the time he leaves the hospital? (2) Is it up to the doctors to tell the patient what is wrong with him and what to do about his problems, or does the patient have to try to find out for himself? (3) What should we say to people "outside" about having been in hospital? (4) How many people have relapses and what are the reasons? (5) If a patient's problems are connected with job, family or other environmental factors, is it necessary to change those circumstances in order to get better? From any one of these questions, of course, subsidiary questions may develop and occupy a whole meeting.

Usually the patients are able to

find satisfactory answers to their own questions, which are often discussed in relation to one member's personal problem. For example: Miss M., who had not previously participated and who was to be discharged that day, began to cry and said she was afraid she would break down as soon as she left the hospital. If she got sick when she got home, she would be afraid to phone her doctor and her relatives were not sufficiently interested in her to take the trouble. At once, several members offered to take turns phoning her every day. She agreed that she would be able to tell them if she were sick, and they promised to speak to her doctor and let her know what he suggested. Miss M. was considerably reassured by this and admitted she now felt better about leaving. As important, however, was the extensive discussion of the various ways of obtaining help from the hospital should this become necessary, which reassured and informed a number of members with similar fears.

Group interaction provides the patients with criteria for reality testing. Mrs. B. is an example of this: She had learned on the ward to associate with others and to get satisfaction from inter-personal relationships. She realized that this was an important factor in her improvement. However, she was afraid she would slip back into her old, secluded way of life when she went home because she had a baby and could never get out. She could not afford baby-sitters, and even though her husband could look after the baby occasionally, she was fearful of going out alone. Through discussion she realized that family members and neighbors who were presently looking after the baby would probably be willing to lend a hand after she returned home. She was also informed that volunteers attached to her church would do baby-sitting.

### Therapy Limits Realized

There are numerous examples of ways patients in the group are able to integrate the knowledge and experience learned in therapy and to apply this to their everyday life. One of the most important of these is the formulation of the limitations of therapy. A man says: "The doctor can't solve our problems for us. The doctor helps us to get stronger so that we can figure out our problems for ourselves." Or patients may swap practical hints on tension reduction. At one meeting, patients were discussing their difficulties on getting along with people. One woman said she never wanted to go to the show when her husband asked her. This made them both unhappy, and she could now see how the relationship would be improved by her compromising and going with him from time to time. Another patient remarked, "It often hurts more not to go than to go. We sometimes put up obstacles for ourselves," and there followed some more discussion of this question of the necessity for compromise between one's own wishes and those of others, and the long-term gains in a relationship that may follow short-term sacrifices of one's own wishes.

Tangible data as to the results of such a group are difficult to provide. However, general observations by the group leaders and hospital staff indicate that patients who participated actively showed less anxiety at the time of discharge, and were better able to cope with their difficulties in the early post-discharge period.

# PSYCHIATRIC AND DETENTION WINDOWS

Youngstown Receiving Hospital, Youngstown, Ohio; Arsene Rousseau, Architect; Felix Pesa & Sons, Contractors.

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# The Institute for Psychosomatic & Psychiatric Research and Training

## Michael Reese Hospital Medical Center, Chicago, Illinois

Architects: LOEBL, SCHLOSSMAN AND BENNETT

Entrance to the Institute

# The Institute for Psychosomatic & Psychiatric Research & Training

## MICHAEL REESE HOSPITAL MEDICAL CENTER, CHICAGO

By ROY R. GRINKER, M.D., Director

THE INSTITUTE for Psychosomatic and Psychiatric Research and Training at the Michael Reese Hospital was built in 1951. It was planned as part of an expanding medical center. Complete medical, surgical, laboratory and auxiliary consultative services were already available; a quarter-mile tunnel connects the Institute with each building on the campus.

The Institute was the culmination of a long period of development, started when, in 1922, the hospital was one of the first in the country to open a community psychiatric clinic. The $1,650,000 Institute was built to study and provide care for acutely disturbed patients requiring relatively short-term therapy, although increasing numbers of long-term patients are also received. As well as several categories of adult facilities, there is a division for emotionally disturbed children.

The Institute is located on the south end of the new campus, allowing for a large expanse of landscape around the building. Earth was moved to place the structure on a small hill, part of the general plan to provide a rolling landscape, rather than flat greens.

Before any plans were prepared, the architects sat down with the staff to learn step by step the inter- and intra-relationships of the various functions of the Institute. A detailed list of each type of facility was made and the designers analyzed each one. The

The lobby, just inside the main entrance, is spacious and sunny. The information desk at its rear (not shown) overlooks the entranceways to the three wings and also has full view of the elevator. A separate waiting room is located just off the lobby.

*Photos by Hedrich-Blessing*

functional relationship between all facilities was considered, including an analysis of the flow of human traffic. The architects also toured the country to see some of the best and most modern psychiatric hospitals.

The plan provides for 80 beds, but provision was made in the design for future expansion. The foundations are built to allow the addition of two extra stories and the basement kitchen can easily be expanded to the floors above. The present building contains 82,000 square feet of floor space, on four stories.

The final plans provided a T-shaped floor plan, with the main stem pointing roughly north and the cross wings east and west. Patient bedrooms, dormitories, dayrooms, activity areas and other facilities are oriented to the south, administrative offices, nursing units and research facilities to the north.

The design of the building avoids a gloomy "institutional" feeling. Large windows at the ends of the corridors cast sunlight into the halls; each room has a harmonious color scheme; windows are large yet not obviously "safe"; bathrooms and closets are adequate. All this has been accomplished with no waste of floor space in a tight design. Patients are restricted as required, but have no feeling of being confined or cooped up.

On all floors the wings intersect to form a central area for observation, control and service needs. On the first floor this central area contains the information and admission desk, at one end of the sunny lobby. A comfortable waiting room is provided just off the lobby. Administration offices and admitting rooms are in the east and west wings of this floor. Since these areas are away from the public rooms, the director, his secretary, his associates and the nursing supervisor are afforded complete privacy.

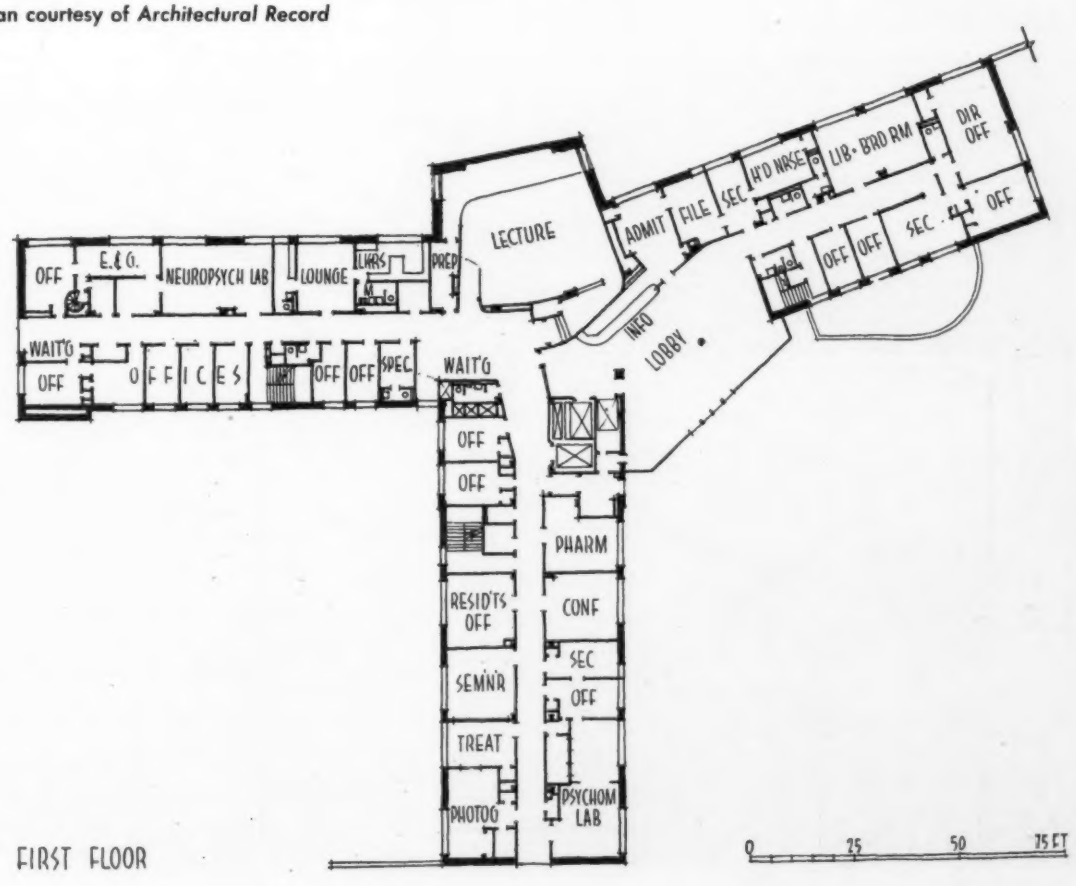
South of the lobby is a 110-seat auditorium, across the corridor from the training department and easily accessible from class rooms. Because this auditorium is near the elevator, which is under constant observation from the admission desk, patients can easily be taken to it. Just outside the auditorium is a waiting area, a cloak room and a special "prep room" where patients can wait before being brought into the auditorium.

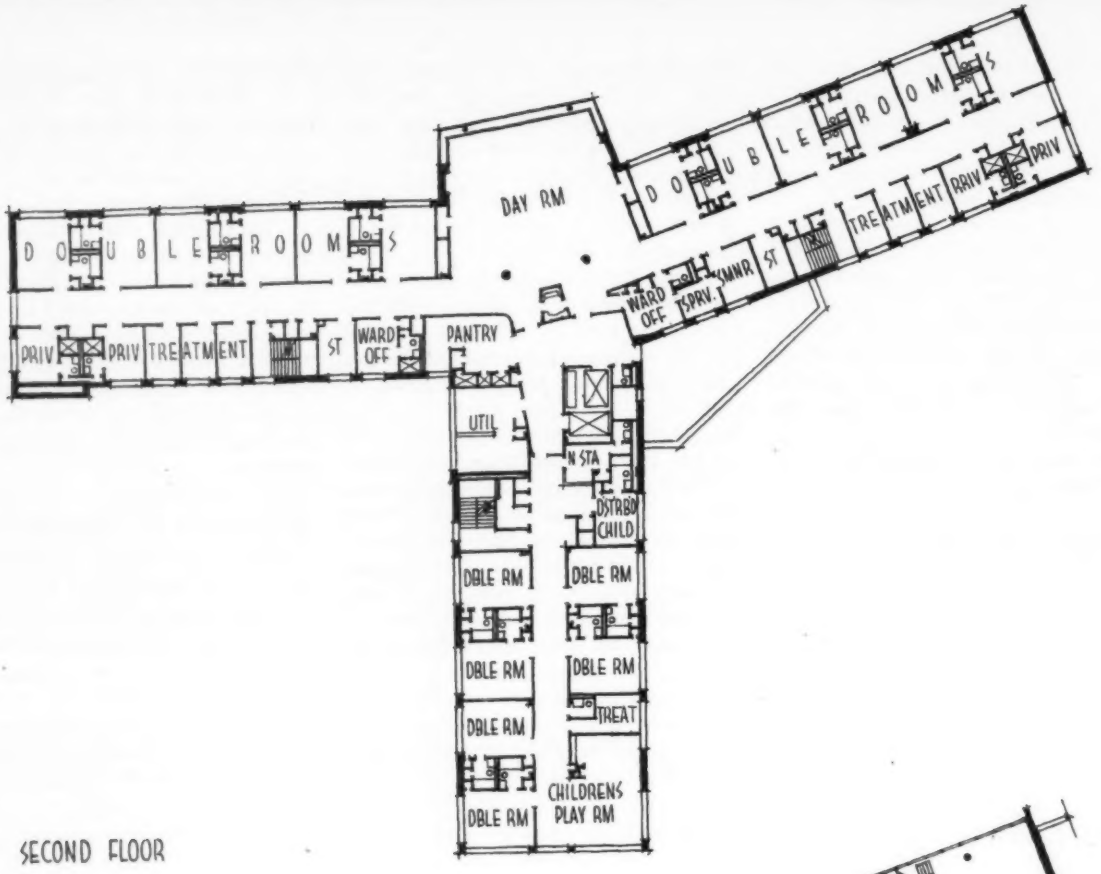
In the auditorium, clinical presentations can be made through the use of a projection booth, blackboard or on any part of the curtained stage. The overhead lighting, as well as illuminated walls beside the stage, casts soft fluorescent light, giving a pleasant, peaceful feeling, yet at the same time drawing attention to the front of the assembly.

## Research & Training Areas

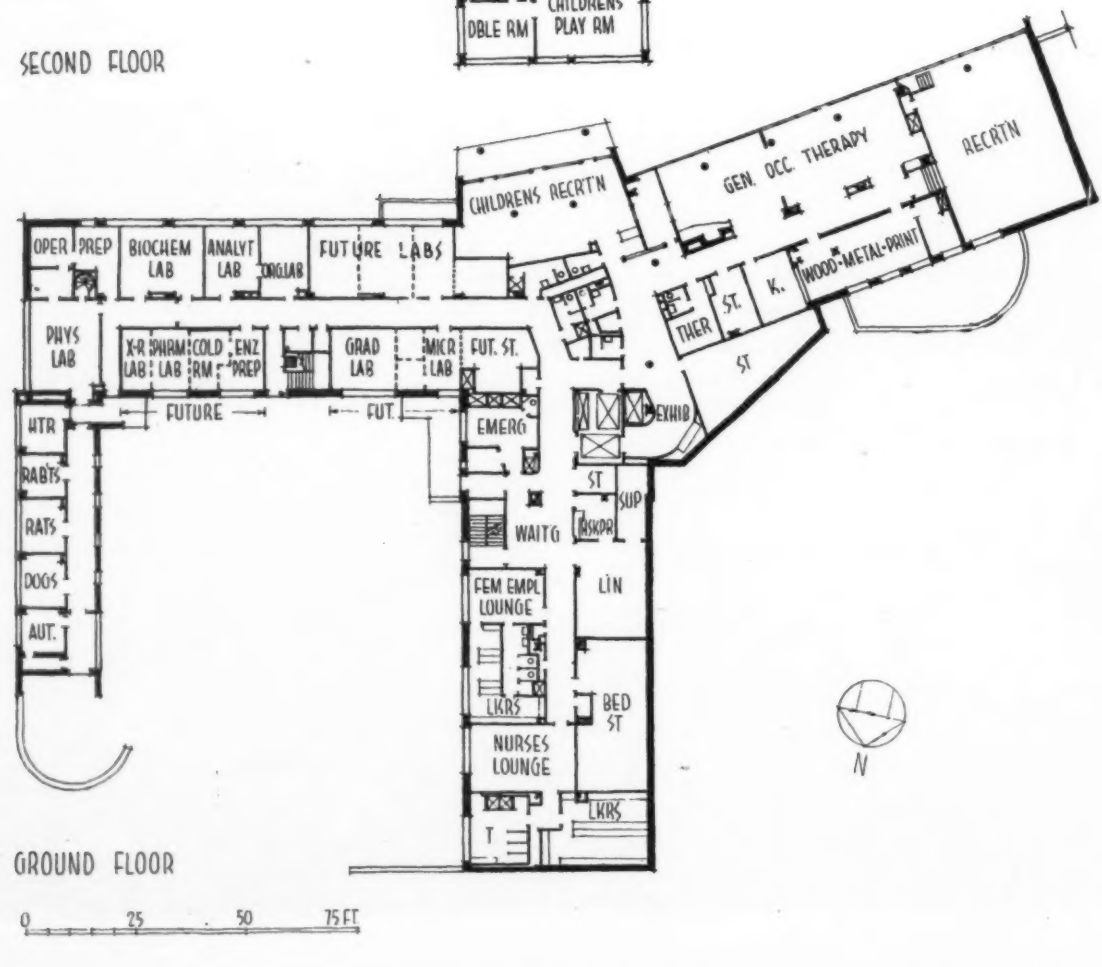
Twenty percent of the building is devoted to research and training, and these special areas are divided between the first and the ground floors. The east wing of the first floor houses human research, while the same wing of the ground floor provides for animal research. The north wing of the first floor holds offices, classrooms and

Floor plan courtesy of *Architectural Record*






SECOND FLOOR




GROUND FLOOR

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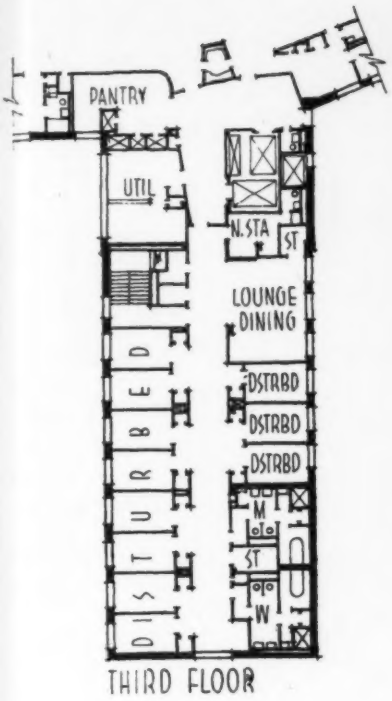

THIRD FLOOR

observation rooms utilized in training psychiatric residents and nurses. A special stairway gives easy access between these research and training areas so that they are entirely isolated from the public rooms and patient areas.

### Patient Areas

Each patient floor is divided by a common day room area, a design feature which provides considerable flexibility. These day rooms are pleasant and large, providing for living, lounging and passive recreation. Since each day room can be divided by two partitions, each floor can thus be separated into two departments, making possible a large variation in the number of beds devoted to different patient classifications.

Seventy percent of the space in the Institute building is devoted to patients, who are divided into five categories: the psychosomatic division, two divisions for mildly disturbed psychotic patients, the division for child care, and a special division for disturbed patients.

The most seriously disturbed and acutely ill patients are housed in the north wing of the third floor. (As they progress in mental health, they move to the second floor and then back to the other third floor wings.) On this

**The semi-private rooms on the second floor are exceptionally large; each has an entire wall covered with windows protected by security screens.**

**Day rooms (above) are used for lounging and passive recreation. More active diversions are carried on in the ground-floor recreation room (below), which has an adjoining area for TV-viewing.**

**The occupational therapy suite opens onto an enclosed garden, which is equipped for outdoor relaxation and recreation. Small picture shows other side of garden enclosure and the rear of the building.**

wing are cubicles that contain only a bed and have a soundproof door, forming seclusion units similar to those in psychopathic hospitals. Patients use central, communal toilets and a lounge room, and are always under direct supervision of the nurses. Eleven beds were originally planned, but experience has shown the need for 15 to 20.

From the third floor north, patients progress to the completely locked east wing of the second floor. The rooms here are of large size, perhaps the largest of any modern hospital, with the windows and protective screens covering an entire wall.

This wing was originally intended for psychosomatic patients as well as those far advanced in treatment. Practice showed need for another unit for severely disturbed patients. Those placed here are less disturbed than on three north but more so than those on the other two third floor wings.

Patients "promoted" from this wing eventually go to the east and west wings of the third floor, which consist of single and double rooms. It is the need of the patient and not the cost that determines which he is allotted. Rooms here are assigned by the physician. In this way those who cannot socialize with others are placed in single rooms and others, who require companionship, are placed in semi-private rooms. Only the corridor door is locked.

Those persons furthest along the road to recovery live in the west wing of the second floor. It is an open unit, with nothing locked, the patients having their own telephones and the freedom to come and go as they please. The rooms on this floor are very large, lending an air of openness and freedom which fits in with the chief architectural theme. The north wing on the second floor is the children's unit.

Patients can be taken by elevator to the ground floor, where the recreational and occupational therapy areas are located entirely separately from the research area. The patients' area opens only to the south, leading to a pleasant, enclosed garden. This garden is divided into two areas—one with sunchairs, tables, barbecue and badminton court for the adults, and the other with slide, swings, and a pool for the children. The arrangements are designed to afford freedom of movement and outdoor exercise, while minimizing the risk of suicide or escape.

The large recreation room on this floor can be partitioned by sliding doors into two areas; one is the "fireside room" with a large brick fireplace, lounging chairs, television set and a phonograph; the other contains a loom, tables, chairs, drawing-easel and other materials for hobbies. A small kitchen, a workshop and a paintshop are directly off this section of the room. The paintshop, which contains all the inflammable materials which may be used, is fitted with explosion-proof lights and switches.

This arrangement separates the noisy crafts from the quieter area. The whole room can be used for dancing, social activities and staff meetings. A gymnasium for basketball, table tennis and badminton completes patient facilities on this floor.

Likewise, the service areas, in the basement, are completely separate from all other areas. The tiled kitchen, with stainless steel equipment, was designed by a former hospital chief dietitian; an especially interesting feature is a conveyer belt assembly line for making up patients' food trays.

The temperature in the whole building is controlled by radiant heating and air conditioning.